APPLICATION FOR ADOPTION

State Form 49794 (7-00) / FPP 0026

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this form cannot be processed without it.

County

CENTRAL OFFICE / COUNTY USE ONLY

Enter resource ID number assigned by the Indiana Child Welfare System (ICWIS). If the number is less than 9 digits, use zeros for first spaces.

INSTRUCTIONS: Include the full name of all persons living in your home at present. For further entries, use the reverse side of this form.

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER *	PLACE OF BIRTH	RELATION TO FAMILY	OCCUPATION OR SCHOOL GRADE	NAME OF EMPLOYER
Applicant A						
Applicant B						
Children						
Others						

Present address *(number and street, city, state and ZIP code)*

Directions to home

Telephone number *(home)* ( )

Telephone number *(office)* ( )

Number of children you want to adopt

Age and sex

Please indicate the special needs characteristics of the children you would consider adopting.

- ☐ None
- ☐ Minority child over age 2
- ☐ Non-minority child over age 6
- ☐ Medical / physical challenge
- ☐ Mental / emotional challenge
- ☐ Minority sibling group
- ☐ Non-minority sibling group
- ☐ Behavior challenge
- ☐ Adolescent
- ☐ Educational challenge

What led you to apply for adoption?

- ☐ T.V.
- ☐ Radio
- ☐ Internet
- ☐ Newspaper
- ☐ Billboard / Poster
- ☐ Family / friends
- ☐ My Forever Family Program
- ☐ Licensed child placing agency / list
- ☐ State-sponsored recruitment activities
- ☐ Faith-based organization
- ☐ Other *(specify)*

Reasons for wanting to adopt children in need of services.

Have you ever applied to adopt? ☐ Yes ☐ No

If Yes, from whom?

Have you ever adopted a non-related child? ☐ Yes ☐ No

If Yes, please explain:

How many children do you have of your own?
Applicant A _____
Applicant B _____

Family income per month
$

Religion
Applicant A _____
Applicant B _____

Place of marriage

Date of marriage

Number of rooms in your home

Do you have a yard? ☐ Yes ☐ No

Race
Applicant A _____
Applicant B _____

Continued on reverse side

Please give, as references, the names of your physician and four persons (non-relatives) who know your family life.

NAME	STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER
Name of physician			( )
			( )
			( )
			( )
			( )

To be completed by adoptive applicants for placement of a non-special needs child(ren).

I, the undersigned adoptive applicant, understand that, according to IC 12-19-1-14, the county office may charge a placement and/or a home study fee for placement of a non-special needs child(ren).

Signature of applicant A	Date signed	Signature of applicant B	Date signed

To be completed by all adoptive applicants.

I certify that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge.

Signature of applicant A	Date signed	Signature of applicant B	Date signed

Use for additional entries from front, if required